STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF VALPARAISO	1300 VALE PARK ROAD VALPARAISO, IN46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. Survey dates: September 6, 7, and 8, 2011 Facility number: 012181 Provider number: 012181 AIM number: N/A Survey Team: Kelly Sizemore, RN-TC Sheila Sizemore, RN Regina Sanders, RN Marcia Mital, RN (September 7, 2011) Census bed type: Residential: 71 Total: 71 Census payor type: Other: 71 Total: 71 Sample: 7 Supplemental sample: 8 These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 9/13/11 Cathy Emswiller RN	R0000	The ffollowing is tthe Plan off Correctton ffor tthe Rittenhouse Senior Living off Valparaiso in regards tto tthe Sttattementt off Deffciencies datted Septtembe8, 2011. This Plan off Correctton is nott tto be consttrued as an admission off or agreementt witth tthe ffndings and conclusions in tthe Sttattementt off Deffcienc,es or any relatted sanctton or ffne Ratther, itt is submitted as conffrmatton off our ongoing effortts tto comply witth sttattuttory and regulattory requirementts In tthis document, we have outtlined speciffc acttons in response tto identtffed issues We have nott provided a dettailed response tto each allegatton or ffnding, nor have we identtffed mittgattng ffacttorsWe remain committed tto delivery off qualitty healtth care services and will conttnue tto make changes and improvementt tto sattsffy tthatt objecttve.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview, and record review, the facility failed to ensure the residents' rooms were clean, related to multiple carpet stains in 6 of 8 resident apartments observed during the environmental tour. This had the potential to affect 7 residents who resided in the 6 apartments. (Apartment 104, 114, 200, 217, 232, and 312) Findings include: During the initial tour of the second floor apartments on 09/06/11 at 10:05 a.m. through 10:55 a.m. with LPN #1, there were multiple dark stains on the carpeting in apartments 200, 217, and 232. During the environmental tour with the Maintenance Supervisor on 09/07/11 at 9:20 a.m. through 10:05 a.m., there were multiple dark stains on the carpeting in apartments 104, 114, 200, 217, 232, and	R0144	The following corrective action has been taken: 1. Apartments 104, 114, 200, 217, 232, and 312 will have their carpets cleaned and sprayed with stain resistant spray on 09/22/2011. To ensure this practice does not recur and provide systemic changes:All residents have the potential to be affected by this practice. The Housekeeping Diretor or designee will monitor all resident rooms during weekly cleaning to ensure carpets are clean and in good repair. If carpets are in need of cleaning or repair, Housekeeping Director or designee will alert Maintenance Director through work order procedure. To monitor the effectiveness of these corrective actions: The ED or designee shall monitor for continued compliance by completing building rounds daily for 30 days. After 30 successful days, rounds would go to weekly for 4 weeks. After 4 successful weeks, rounds would go to monthly for an indefinite	10/08/2011

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	312. During an interview with the Maintenance Supervisor during the observations, he indicated "Either the residents or the staff let him know if carpets need cleaned." A facility policy, dated 09/01/09, titled, "Housekeeping Services received from the Administrator as current, indicated, "...PURPOSE To ensure all residents live in a clean, homelike environment...Cleaning of residents' rooms will be done by Community staff..."		amount of time.	

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R0148	(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure equipment was in clean condition and free of hazards related to large accumulations of lint in and around the lint filters for 10 of 11 clothes dryers in 4 of 4 laundry rooms. This had the potential to affect the 71 of 71 residents who reside in the facility. Findings include: During the environmental tour with the Maintenance Supervisor on 09/07/11 at 9:20 a.m. through 10:05 a.m., the following was observed: There were 3 of 3 dryers in the first floor Laundry Room with a large accumulation	R0148	The following corrective action has been taken: 1. The 11 clothes dryers were cleaned on September 7, 2011. To ensure this practice does not recur and provide systemic changes: All residents have the potential to be affected by this practice. Nursing staff will be inserviced on proper laundry procedures 09/27/2011. Maintenance staff will be inserviced on a written program for maintenance to ensure the continued upkeep of the facility on 09/27/2011. To monitor the effectiveness of these corrective actions: The Housekeeping Director or designee will check the laundry room dryers daily during cleaning rounds for an indefinite amount of time. Maintenance Director will round weekly for 4 weeks to ensure compliance in this area. After 4	10/08/2011

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	of lint in the lint filters. During interview at that time, the Maintenance Supervisor indicated the staff are suppose to clean them out prior to using the dryers. He indicated they should have been cleaned out after the dryers had been used. There were 3 of 3 dryers in the Memory Care Unit Laundry Room, which had a large accumulation of lint and debri under and around the lint filters. During interview at that time, the Maintenance Supervisor indicated the staff were suppose to use pipe cleaners to clean the dryers out and the pipe cleaner must have been misplaced. There was 1 of 2 dryers in the second floor Laundry Room, which had a large accumulation of lint and debri under the lint filter. There were 3 of 3 dryers in another second floor Laundry Room, which had a large accumulation of lint and debri in and around the lint filters. During interview at that time, the Maintenance Supervisor indicated the staff had not scooped the lint out of the dryers. An undated facility policy, titled, "Laundry Procedures", received from the Administrator as current on 09/07/11 at 12:30 p.m., indicated, "...9. CLEAN THE		successful weeks, rounds will go to monthly for an indefinite amount of time.	

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	DRYER LINT TRAP AFTER EACH USE!!!..."			
R0154	(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to keep the kitchen equipment and kitchen areas clean related to, dirty bowls and bread plates, dirty rails on the metal bread rack, an opened paperback novel laying across the top of the toaster, 2 dirty grease traps and shelves, and an opened garbage lid for 1 of 1 kitchen. The deficient practice has the potential to affect 71 of 71 residents, who were served meals from the facility kitchen. Findings include: Observations on 9/6/11, during the initial kitchen tour with the Dietary Manger, beginning at 9:50 a.m., the following was observed: Kitchen: 1. There were 2 of 10 bowls with dried food inside the bowls. The Dietary Manager identified the dried food as oatmeal.	R0154	The following corrective action has been taken: 1. The bowls and breadplates were immediately re-washed. 2. The novel was removed 09/06/2011. 3. Rails on the bread rack were cleaned on 09/06/2011. 4. Spice shelf was cleaned on 09/06/2011. 5. The lid to the garbage can was closed. 6. The 2 grease traps under the burners were cleaned on 09/06/2011. To ensure this practice does not recur and provide systemic changes: All residents have the potential to be affected by this practice. Dietary staff will be inserviced on 09/21/2011 regarding cleaning lists and responsibilities. To monitor the effectiveness of these corrective actions: The Food Service Director or designee will round daily on kitchen cleanliness to ensure all procedures are being followed for an indefinite amount of time.	10/08/2011

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	2. There were 2 of 11 bread plates with black specks on them. 3. There was a paperback novel opened and laying across the top of the bread toaster. The Dietary Manager indicated she "did not have a problem with that." 4. The rails on the metal bread rack had food crumbs on them. The Dietary Manager indicated the rails were cleaned weekly. 5. There were spilled spices along the spice shelf. 6. The bottom shelf of the meat slicer table was dirty with dried food crumbs. During interview at that time, the Dietary Manager indicated the shelf was dirty and would be cleaned. 7. The sliding lid to the garbage can by the prep table was opened, exposing waste. 8. The 2 grease traps under the stove burners had a build up of dried burnt food.			

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R0216	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure a resident was evaluated for self administration of medications, for 1 of 1 resident who self administered medication in a total sample of 7. (Resident #13) Findings include: Upon interview during the initial tour on 9/6/11 at 10 a.m. with LPN #2, she indicated resident #13 self administered her medications. Resident #13's record was reviewed on 9/6/11 at 12:45 p.m. Resident #13's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and coronary artery disease. Resident #13 was admitted to the facility on 8/26/11.	R0216	The following corrective action has been taken: 1. Resident #13 was administered a Self Administration Assessment on 09/13/2011. To ensure this practice does not recur and provide systemic changes: All residents who self medicate have the potential to be affected by this practice. Therefore, all nursing staff will be re-educated on facility policy and procedure for self administration of medication on September 27, 2011. To monitor the effectiveness of these corrective actions: The Director of Nursing or designee will audit all residents charts upon admission and every six months for an indefinite amount of time.	10/08/2011

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	A "Rittenhouse Senior Living of Valparaiso Physician History and Plan of Care" form, dated 8/8/11 (prior to admission) indicated "Medication Administration...May self-administer medications with associate supervision. Medication is self-administered with associate supervision and cueing" was checked. Admission physician orders, dated 8/26/11, included, but were not limited to, "Self Administer" A "MENTAL STATUS QUESTIONNAIRE," dated 8/26/11, indicated the resident had a score of 9 indicating (no or mild impairment). An undated "MEDICATION SELF ADMINISTRATION ASSESSMENT FORM," was left blank. An undated facility policy titled, "Medication Self Administration Assessment/Criteria," received as current from the DoN (Director of Nursing) on 9/7/11 at 8:40 a.m., indicated "POLICY: Residents will be given the opportunity, if identified as mentally and physically able to, self-administer their own medications. Ability will be determined by the most recent assessment...The SAM (SELF ADMINISTRATION OF			

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	MEDICATIONS) MSQ (MENTAL STATUS QUESTIONARE (sic) is designed to determine if a resident in the AL (Assisted Living) community is able to safely SAM...PROCESS: For residents preferring to self-administer medication, an MSQ and assessment (underlined) will be completed..." During an interview with the DoN, on 9/6/11 at 1:35 p.m., she indicated the Self Administration Assessment should have been done when the resident came in.			

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, record review, and interview, the facility failed to update a resident's Service Plan, related to a port under the skin used for dialysis for 1 of 7 residents reviewed for Service Plans in a sample of 7. (Resident #26) Findings include:	R0217	The following corrective action has been taken: 1. Resident #26' s AV shunt was added to her service plan on 09/19/2011 stating shunts location and per facility policy all other care will be provided through the dialysis center unless the shunt presents any problematic signs and symptoms.To ensure this practice does not recur and provide systemic changes: All residents	10/08/2011

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	Upon interview during the initial tour on 09/06/11 at 10:05 a.m., LPN #1 indicated Resident #26 had a port in her upper arm. She indicated the port was used for dialysis. She indicated the resident received dialysis three times a week. During an observation on 09/06/11 at 1:40 p.m., Resident #26 was sitting in her chair in her room. During interview at that time, resident # 26 indicated she had a port in her right upper arm. Upon observation at that time, there was a port under the skin of the resident's right upper arm. Resident #26's record was reviewed on 09/06/11 at 1 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and diabetes. An admission assessment, dated 04/13/11, indicated the resident had an AV (arterial/venous) shunt in her right upper arm. The resident's Service Plan, dated 04/07/11, indicated the resident received dialysis three times weekly. The Service Plan lacked documentation to indicate the resident had a port in her upper right arm and what type of care/precautions were needed for the port.		who have an AV shunt have the potential to be affected by this practice. Therefore, all nursing staff will be re-educated on facility policy and procedure for Service Plans on September 27, 2011. To monitor the effectiveness of these corrective actions: The Director of Nursing or designee will audit all residents Service Plan upon admission and every six months and any significant change in condition for an indefinite amount of time.	

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	During an interview on 09/06/11 at 1:30 p.m., the Director of Nursing indicated the facility does not address the port for dialysis. She indicated it did not need to be on the Service Plan because dialysis cares for the port.			
R0273	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to follow safe food handling standards related to unlabeled and undated foods for 1 of 1 kitchen. This deficient practice has the potential to affect 71 of 71 residents, who are served meals from the facility kitchen. Findings include: Upon Observations on 9/6/11, during the initial kitchen tour, with the Dietary Manager, beginning at 9:50 a.m., the following was observed: Kitchen: 1. There was a pint glass jar of strawberry jelly, as identified by the Dietary Manager	R0273	The following corrective action has been taken: 1. The pint jar of strawberry jelly was correctly labeled on 09/06/2011. 2. The six quart plastic container of prunes was correctly labeled on 09/06/2011. 3. The plastic container of scrambled egg mixture was disposed of on 09/06/2011. To ensure this practice does not recur and provide systemic changes: All residents have the potential to be affected by this practice. Dietary staff will be inserviced on 09/21/2011 regarding Safe handling of food precedures and proper labeling procedures. To monitor the effectiveness of these corrective actions: The Food Service Director or designee will round daily on kitchen coolers and freezers to ensure all procedures are being followed for	10/08/2011

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	in the cooler. The pint glass jar did not contain a label identifying the contents of the jar or a date of when the jelly was opened. 2. There was a six quart plastic container in the cooler, containing prunes as identified by the Dietary Manager. The container did not have a label identifying the contents of the container or a date of when the prunes were opened. During interview at that time, the Dietary Manager indicated the labels must have come off. 3. There was a plastic container identified by the Dietary Manager as a scrambled egg mixture in the "Low Boy" refrigerator. The plastic container had the date of 8/25/11 and was not labeled with the name of the contents. During interview at that time, the Dietary Manager indicated the scrambled egg mixture "was bad." 4. There was a plastic container, containing pickles as identified by the Dietary Manager. The container did not have a label or date. A facility policy, titled "Leftovers," dated 1/10, indicated "...1. Leftovers may be stored in the refrigerator for no longer then 7 days...6. Label pan with contents,		an indefinite amount of time.	

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	date, and time placed in refrigerator..."			
R0298	(2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview, and record review, the facility failed to ensure residents' eye medications and insulin were dated when the containers were opened and failed to ensure an eye medication was not expired for 6 resident's in a supplemental sample of 8 (#2, #12, #39, #46, #47, and #59). The facility also failed to date when opened, 1 of 1 multiple dose vial of Aplisol (Tuberculin testing), for 1 of 3 medication	R0298	The following corrective action has been taken: 1. All medications in the in the nurses cart and refridgerator were audited for expiration and date opened dates. Any medication that was expired was destroyed per facility policy. To ensure this practice does not recur and provide systemic changes: All residents have the potential to be affected by this practice. Nursing staff will be re-educated on facility medication storage and labeling	10/08/2011

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		A. BUILDING 00 B. WING	09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF VALPARAISO	1300 VALE PARK ROAD VALPARAISO, IN46383

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	refrigerators, this had the potential to affect 88 residents who reside in the facility. (Second Floor Medication Room and First Floor medication cart) Findings include: 1. During an observation of the second floor medication cart and refrigerator with QMA #3 and LPN #1 on 09/06/11 at 12:40 p.m., the following was observed: There was an undated, opened bottle of Systane and Refresh eye drops, labeled with Resident #59's name. QMA #3 indicated the bottles were not dated when they were opened. There was an undated, opened bottled of Dorzolanide eye drops with an expiration date of 08/2011, labeled with Resident #39's name. QMA #3 indicate the eye drops were expired. In the medication refrigerator there was an undated, opened vial of 70/30 insulin labeled with Resident #46's name, an undated, opened vial of Lantus insulin labeled with Resident #47's name, and an undated, opened vial of Aplisol. LPN #1 indicated the insulin was good 28 days after it had been opened. She indicated she was not sure when the insulin or the Aplisol had been opened.		on 09/27/2011. To monitor the effectiveness of these corrective actions: The Director of Nursing or designee will monitor all medications stored in the refrigerator and the medication cart weekly for 4 weeks of continuous compliance, it will then move to monthly audits. The consultant pharmacist will audit the refrigerator and medication cart during their facility visits also.	

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	2. During an observation of the first floor medication cart on 09/07/11 at 10:15 a.m. with LPN #4, the following was observed: There was an undated, opened bottle of Travatan eye drops, labeled with Resident #2's name. LPN #4 indicated the eye drop bottle had not been dated when opened. There was an undated, opened tube of Gentral PM eye ointment and Lubrifresh eye ointment labeled with Resident #12's name. During interview at that time, LPN #4 indicated the eye medication had been dispensed 08/08/11. She indicated the eye ointments were not dated when they were opened. A facility policy, dated 10/23/09, titled, "PREPARATION FOR MEDICATION ADMINISTRATION", received from the Director of Nursing as current, indicated, "...The date opened and the initials of the first person to use the vial are recorded on multi dose vials..."			

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R0304	(e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to ensure medications were stored securely at times, related to unlicensed staff having keys to the Memory Care Unit Medication Room. This had the potential to affect 28 of 28 residents who live on the unit, with the diagnoses of Alzheimer's disease and/or dementia. (Medication Room, Resident #76, CNA #5, and CNA #6) Findings include: During an observation on 09/06/11 at 1:15 p.m., on the Memory Care Unit, CNA #6 was observed to unlock the Medication Room door and enter the room. The CNA indicated she was leaving for the day and returning her key and pager to the drawer in the Medication Room. CNA #6 indicated all of the CNAs have a key to the Medication Room. CNA #5 was observed on 9/6/11 at 1:20 p.m., to unlock the Medication Room door with a key and enter the room. A bottom right hand unlocked drawer was	R0304	The following corrective action has been taken: 1. The nurses station on the Memory Care Unit had the lock replaced with a key only the nurses have access to on 09/06/2011. To ensure this practice does not recur and provide systemic changes:All residents have the potential to be affected by this practice. The Director of Nursing has the nurses station key and is the back up to the nurses. To monitor the effectiveness of these corrective actions: The Director of Nursing will monitor the nurses keys and ensure that the nurses station key is only given to qualified personnel.	10/08/2011

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	observed at the above time to contain the following medications belonging to Resident #76: Geodon (anti-psychotic) 20 milligram capsules Prilosec (stomach medication) 20 milligram tablets Niacin (supplement) 500 milligram tablets Boniva (treatment for osteoporosis) 150 milligram tablets Aspirin (pain reliever) 81 milligram tablets Klor-Con (potassium supplement) tablets Plavix (blood thinner) 75 milligram tablets Benicar (antihypertensive) 20 milligram tablets Diltiatiazem HCL (heart medication) 240 milligram capsules Isosorbide MOM CR (antianginal medication) 30 milligram tablets During an interview on 9/6/11 at 1:45 p.m., the DoN (Director of Nursing) indicated the CNAs all have keys to unlock the door to the Medication Room. The DoN indicated the CNAs do not have a key to the medication carts. The DoN indicated the medications should have been locked up.			

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R0410	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to administer a mantoux test for tuberculosis, for 1 of 7 residents reviewed for mantoux testing in a total sample of 7. (Resident #13) Findings include: Resident #13's record was reviewed on 9/6/11 at 12:45 p.m. Resident #13's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and coronary artery disease. Resident #13 was admitted to the facility on 8/26/11.	R0410	The following corrective action has been taken: 1. Resident #13 was administered step 1 of 2 on 09/14/2011. The 2 nd step will be completed within 3 weeks of step 1 being read. To ensure this practice does not recur and provide systemic changes: All residents have the potential to be affected by this practice. Director of Nursing will have facility wide audit completed by 09/24/2011 of all resident TB tests. To monitor the effectiveness of these corrective actions: The Director of Nursing or designee will audit all residents charts upon admission and every six months for an indefinite amount of time.	10/08/2011

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	A "Resident TB/Immunization Record," indicated a mantoux was given on 8/3/11 (prior to admission) and read on 8/5/11 with a result of "0 mm (millimeters)." The record lacked documentation of a first or second step mantoux being given on admission. During an interview with the DoN (Director of Nursing), on 9/6/11 at 1:35 p.m., she indicated the second step was not given within the 21 days. She indicated they should have started over with the mantoux test when the resident was admitted. A facility policy, dated 9/1/09, titled "5.75 Tuberculosis (sic) Screening," received as current from the DoN, on 9/7/11 at 8:40 a.m., indicated "...For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing will employ the two-step method. If the first step is negative, a second test will be performed within one (1) to three (3) weeks after the first test...A record of the date...skin test for tuberculosis shall be maintained in the clinical record..."			